

2011

Assisted Reproductive Technology

Fertility Clinic Success Rates Report

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

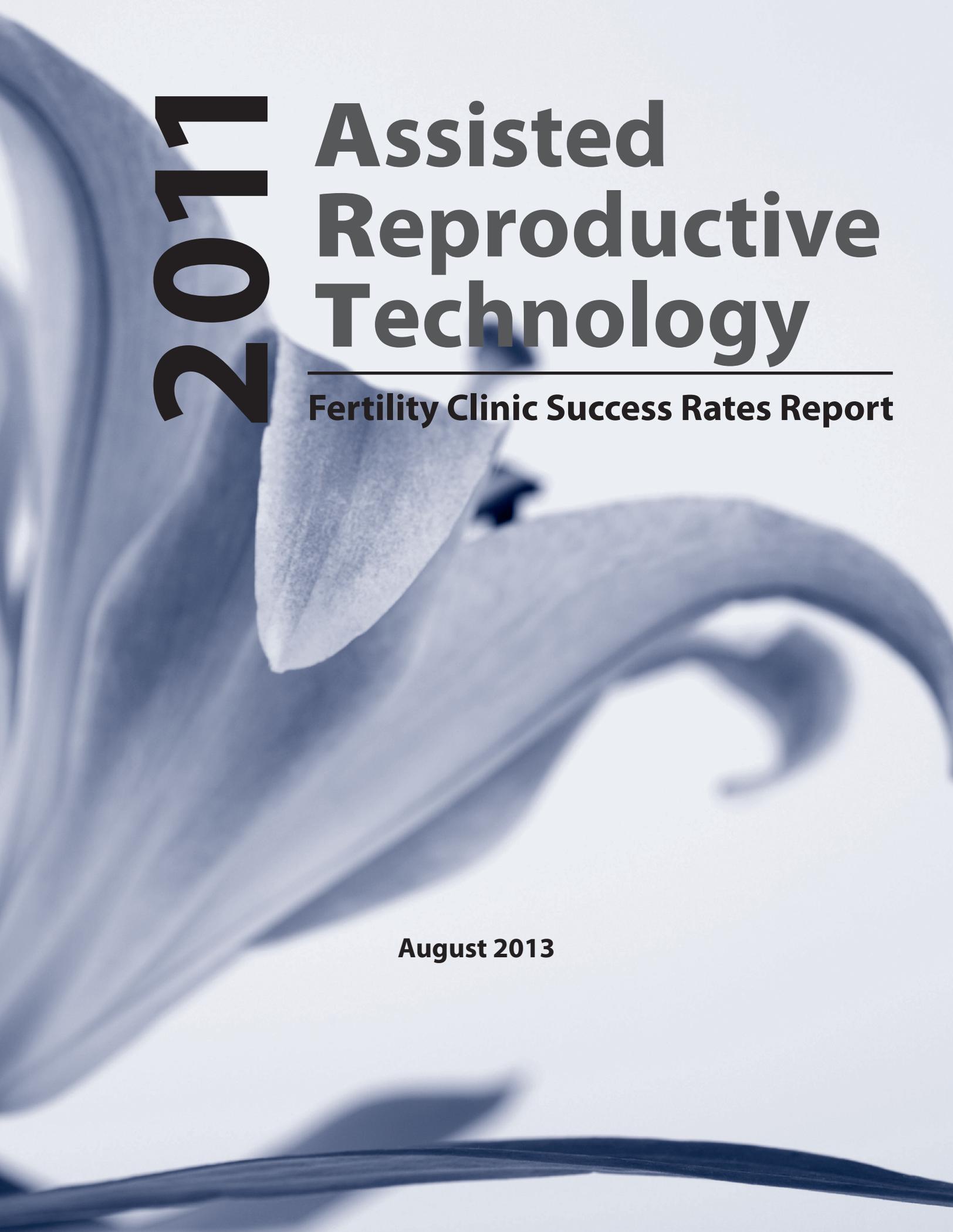


Updates to this report will be posted on the CDC Web site at the following address:

<http://www.cdc.gov/art/ART2011>

For additional information, send an e-mail to cdcinfo@cdc.gov (Subject: ART)

Or write to CDC, ATTN: ART Surveillance and Research Team
4770 Buford Highway, N.E.; Mail Stop F-74; Atlanta, GA 30341-3717.



2011

Assisted Reproductive Technology

Fertility Clinic Success Rates Report

August 2013

Acknowledgments

The Centers for Disease Control and Prevention, the Society for Assisted Reproductive Technology, and the American Society for Reproductive Medicine thank RESOLVE: The National Infertility Association and The American Fertility Association for their commitment to assisted reproductive technology (ART) surveillance. Their assistance in making this report informative and helpful to people considering an ART procedure is greatly appreciated. Appendix D has current contact information for these national consumer organizations.

This publication was developed and produced by the National Center for Chronic Disease Prevention and Health Promotion of the Centers for Disease Control and Prevention in consultation with the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology.

Centers for Disease Control and Prevention

National Center for Chronic Disease
Prevention and Health Promotion

Ursula E. Bauer, PhD, MPH, Director

Division of Reproductive Health

CAPT Wanda D. Barfield, MD, MPH, Director
Kelly Brumbaugh, MPH, CHES

Women's Health and Fertility Branch

Denise J. Jamieson, MD, MPH, Chief
Jeani Chang, MPH
Sheree Lynn Boulet, DrPH
Sara Crawford, PhD
Dmitry Kissin, MD, MPH
Aniket D. Kulkarni, MBBS, MPH
Allison S. Mneimneh, MPH, CPM
Mithi Sunderam, PhD
Yujia Zhang, PhD

American Society for Reproductive Medicine

Linda C. Giudice, MD, PhD, President

Society for Assisted Reproductive Technology

G. David Ball, PhD, President
Kelley Jefferson

The data included in this report and publication support were provided by Westat under Contract No. GS-23F-8144H for the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Suggested Citation: Centers for Disease Control and Prevention, American Society for Reproductive Medicine, Society for Assisted Reproductive Technology. *2011 Assisted Reproductive Technology Fertility Clinic Success Rates Report*. Atlanta (GA): US Dept of Health and Human Services; 2013.

Table of Contents

Preface	1
Commonly Asked Questions About the U.S. ART Clinic Reporting System	3
2011 Fertility Clinic Tables	11
Introduction to Fertility Clinic Tables	13
Important Factors to Consider When Using These Tables to Assess a Clinic	13
How to Read a Fertility Clinic Table	17
2011 National Summary	24
Alabama	25
Alaska	31
Arizona	32
Arkansas	42
California	43
Colorado	118
Connecticut	126
Delaware	135
District of Columbia	137
Florida	141
Georgia	170
Hawaii	179
Idaho	185
Illinois	186
Indiana	214
Iowa	224
Kansas	226
Kentucky	231
Louisiana	235
Maryland	239
Massachusetts	247
Michigan	256
Minnesota	270
Mississippi	275
Missouri	278
Montana	286
Nebraska	287

Nevada	289
New Hampshire	294
New Jersey	295
New Mexico	317
New York	318
North Carolina	356
North Dakota	367
Ohio	368
Oklahoma	379
Oregon	383
Pennsylvania	387
Puerto Rico	407
Rhode Island	410
South Carolina	411
South Dakota	415
Tennessee	416
Texas	424
Utah	467
Vermont	471
Virginia	472
Washington	486
West Virginia	496
Wisconsin	499
Appendix A: Technical Notes	507
Validation of 2011 ART Data	509
Appendix B: Glossary of Terms	511
Appendix C: ART Clinics	517
Reporting ART Clinics for 2011, by State	519
Nonreporting ART Clinics for 2011, by State	557
Appendix D: National Consumer Organizations	559

Preface

For many people who want to start a family, the dream of having a child is not easily realized; about 12% of women of childbearing age in the United States have used an infertility service. Assisted reproductive technology (ART) has been used in the United States since 1981 to help women become pregnant, most commonly through the transfer of fertilized human eggs into a woman's uterus. However, for many people, deciding whether to undergo this expensive and time-consuming treatment can be difficult.

The goal of this report is to help potential ART users make informed decisions about ART by providing some of the information needed to answer the following questions:

- What are my chances of having a child by using ART?
- Where can I go to get this treatment?

The Society for Assisted Reproductive Technology (SART), an organization of ART providers affiliated with the American Society for Reproductive Medicine (ASRM), has been collecting data and publishing annual reports of pregnancy success rates for fertility clinics in the United States and Canada since 1989. In 1992, the U.S. Congress passed the Fertility Clinic Success Rate and Certification Act. This law requires the Centers for Disease Control and Prevention (CDC) to publish pregnancy success rates for ART in fertility clinics in the United States. (For more details about the law, see <http://www.cdc.gov/art/Policy.htm>.) Since 1995, CDC has worked in consultation with SART and ASRM to report ART success rates.

The 2011 report of pregnancy success rates is the seventeenth to be issued under the law. This report is based on the latest available data on the type, number, and outcome of ART cycles performed in U.S. clinics.

The 2011 ART report has three major sections:

- ***Commonly Asked Questions About the U.S. ART Clinic Reporting System.*** This section provides background information on infertility and ART and an explanation of the data collection, analysis, and publication processes.
- ***Fertility Clinic Tables.*** Many factors contribute to the success of ART, including the training and experience of the ART clinic and laboratory professionals, the quality of services, and the characteristics of the patient population. The Fertility Clinic Tables section displays ART results and success rates for individual U.S. fertility clinics in 2011. The section also includes the 2011 National Summary table, which combines data from all clinics.
- ***Appendixes:***
 - Appendix A** provides information about 2011 data validation activities.
 - Appendix B** provides definitions for technical and medical terms used throughout the report.

Appendix C includes the current names and addresses of all reporting clinics along with a list of clinics known to be in operation in 2011 that did not report their data to CDC as required by law.

Appendix D includes the names and addresses of national consumer organizations that offer support to people experiencing infertility.

Success rates can be reported in a variety of ways, and the statistical aspects of these rates can be difficult to interpret. This report is intended for the general public, and the emphasis is on presenting the information in an easily understandable form. CDC hopes that this report is informative and helpful to people considering an ART procedure. We welcome any suggestions for improving the report and making it easier to use. (Please contact us at cdcinfo@cdc.gov [Subject: ART].)

In addition to the *2011 Assisted Reproductive Technology Fertility Clinic Success Rates Report*, CDC also publishes the *2011 Assisted Reproductive Technology National Summary Report* (available in December 2013), which provides an overall national picture that uses 2011 data to answer specific questions related to ART success rates.

Commonly Asked Questions About the U.S. ART Clinic Reporting System

Background Information, Data Collection Methods, Content and Design of the Report, and Additional Information About ART in the United States

1. How many people in the United States have infertility problems?

The latest data on infertility available to the Centers for Disease Control and Prevention (CDC) are from the 2006–2010 National Survey of Family Growth. (For more details about the data, see http://www.cdc.gov/nchs/nsfg/abc_list_i.htm#infertility).

- Of the approximately 62 million women aged 15–44 years in 2010, about 7.4 million, or 12%, had received infertility services at some time in their lives. (Infertility services include medical tests to diagnose infertility, medical advice and treatments to help a woman become pregnant, and services other than routine prenatal care to prevent miscarriage.)
- Additionally, 1.5 million married women aged 15–44 years are infertile (unable to get pregnant for at least 12 consecutive months).

2. What is assisted reproductive technology (ART)?

Although various definitions have been used for ART, the definition used in this report is based on the 1992 law that requires CDC to publish this report. According to this definition, ART includes all fertility treatments in which both eggs and sperm are handled. In general, ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. They do NOT include treatments in which only sperm are handled (i.e., intrauterine insemination) or procedures in which a woman takes drugs only to stimulate egg production without the intention of having eggs surgically retrieved.

The main type of ART is **in vitro fertilization (IVF)**. IVF involves extracting a woman's eggs, fertilizing the eggs in the laboratory, and then transferring the resulting embryos into the woman's uterus through the cervix. For some IVF procedures, fertilization involves a specialized technique known as intracytoplasmic sperm injection (ICSI). In ICSI, a single sperm is injected directly into the woman's egg.

Other types of ART exist, but are rarely performed. **Gamete intrafallopian transfer (GIFT)** involves using a fiber optic instrument called a laparoscope to guide the transfer of unfertilized eggs and sperm (gametes) into the woman's fallopian tubes through small incisions in her abdomen. **Zygote intrafallopian transfer (ZIFT)** involves fertilizing a woman's eggs in the laboratory and then using a laparoscope to guide the transfer of the fertilized eggs (zygotes) into her fallopian tubes.

In addition, ART often is categorized according to whether the procedure used a woman's own eggs (nondonor) or eggs from another woman (donor) and according to whether the embryos used were newly fertilized (fresh) or previously fertilized, frozen, and then thawed (frozen).

3. What is an ART cycle?

Because ART consists of several steps over an interval of approximately 2 weeks, an ART procedure is typically referred to as a **cycle** of treatment rather than a procedure at a single point in time. The start of an ART cycle is when a woman begins taking drugs to stimulate egg production or starts ovarian monitoring with the intent of having embryos transferred. For the purposes of this report, data on **all cycles that were started**, even those that were discontinued before all steps were undertaken, are counted in the clinic's success rates.

4. How do U.S. ART clinics report data to CDC about their success rates?

CDC contracts with a statistical survey research organization, Westat, to obtain the data published in the *Fertility Clinic Success Rates Report*. Westat maintains a list of all ART clinics known to be in operation and tracks clinic reorganizations and closings. This list includes clinics and individual providers that are members of the Society for Assisted Reproductive Technology (SART) as well as clinics and providers that are not SART members. Westat maintains the National ART Surveillance System (NASS), the Web-based data collection system that all ART clinics use to submit data to CDC. Clinics either electronically enter or import data into NASS for each ART cycle started in a given reporting year. SART-member clinics can report directly to SART, and SART submits the data to NASS. The data collected include information on the client's medical history (such as infertility diagnoses), clinical information pertaining to the ART procedure, and information on resulting pregnancies and births.

5. Why is the report of 2011 success rates being published in 2013?

Before success rates based on live births can be calculated, every ART pregnancy must be followed up to determine whether a birth occurred. Therefore, the earliest possible date that clinics can report complete annual data is late in the year after ART treatment was initiated (about 9 months past year-end, when all the births have occurred). Accordingly, the results of all the cycles initiated in 2011 were not known until October 2012. After ART outcomes are known, the following occurs before the report is published:

- Clinics enter their 2011 data into NASS and verify the data's accuracy before submitting the data at the end of 2012 to Westat.
- Westat compiles a national data set in the beginning of 2013 from the data submitted by individual clinics.
- CDC data analysts conduct comprehensive checks of the numbers reported for every clinic.
- Individual fertility clinic tables are available in the spring of 2013 on CDC's Web site at <http://www.cdc.gov/art/ARTReports.htm>.
- Clinic tables and accompanying text for both the printed and electronic versions of the full report are compiled and laid out.

- Necessary changes are incorporated and proofread.
- The report is submitted to the Government Printing Office to begin the printing and production process.

These steps are time-consuming but essential for ensuring that the report provides the public with correct information particularly regarding each clinic's success rates.

6. Which clinics are represented in this report?

The data in this report come from 451 fertility clinics that provided and verified information about the outcomes of the ART cycles started in their clinics in 2011.

Although almost all clinics that provided ART services in the United States during 2011 are represented in this report, data from 30 clinics or practitioners are not included because they did not report as required. Clinics and practitioners known to have been in operation as of January 1, 2011, that did not report and verify their data are listed in this report as nonreporters, as required by law (see Appendix C: Nonreporting ART Clinics for 2011, by State on pages 557–558). Given the estimated number of ART cycles performed in nonreporting clinics, we estimate that ART surveillance covered 97% of ART cycles performed in the United States in 2011. We will continue to make every effort to include in future reports all clinics and practitioners providing ART services.

7. Why aren't the clinics ranked by their success rates?

Because the decision to undergo ART treatment is a very personal decision, this report may not contain all of the information that consumers need to decide which ART clinic or procedure is best for their treatment. Many factors contribute to the success rate of an ART procedure in particular patients, and a difference in success rates between two ART clinics may reflect differences in the groups of patients treated, the types of procedures performed, or other factors. More explanations on how to use the success rates and other statistics published in this report are in the Introduction to Fertility Clinic Tables section (see pages 13–23). The report should be used to help people considering an ART procedure find clinics where they can meet personally with ART providers to discuss their specific medical situation and their likelihood of success using ART. Contacting a clinic also may provide additional information that could be helpful in deciding whether or not to use ART. Because ART offers several treatment options for infertility, there are many other factors that may affect the decision. Going through repeated ART cycles requires substantial commitments of time, effort, money, and emotional energy. Therefore, this report may be a helpful starting point for consumers to obtain information and consider their options.

8. Does this report include all ART cycles performed by the reporting clinics?

This report includes data for all 151,923 ART cycles performed in 2011 by the 451 clinics that reported their data as required. This report also includes 11,116 reported ART cycles started with the intent of cryopreserving (freezing) all resulting oocytes/embryos for potential future use. However, because these cycles did not result in an embryo transfer, they are not included in the clinic success rates and are only reported for each clinic in footnote "e" of their table. This report does exclude 6 cycles started in which a new treatment procedure was being evaluated.

9. How are the success rates determined?

This report presents several measures of success for ART, including the percentage of ART cycles that result in a pregnancy. (Please note that not all pregnancies result in live birth; some pregnancies may result in miscarriage, induced abortion, or stillbirth.) All live-birth deliveries were reported to the ART clinic by either the patient or the patient's obstetric provider. Because this report is geared toward patients, the focus is on the percentage of cycles resulting in live births. Singleton live births are emphasized as a separate measure of success because they have a much lower risk than multiple-infant births for adverse infant health outcomes, including prematurity, low birth weight, disability, and death. Success rates were additionally calculated at various steps of the ART cycle to provide a complete picture of the chances for success as the cycle progresses.

10. What are my chances of getting pregnant using ART?

Many consumers ask this question because they assume that the pregnancy will lead to a live birth. Unfortunately, not all ART procedures that result in a pregnancy lead to the delivery of a live infant. For example, 101,213 fresh nondonor ART cycles were started in 2011. Of those, 36,266 (36%) led to a pregnancy, but only 29,598 (29%) resulted in a live birth. In other words, 6,668 (18%) of ART pregnancies did not result in a live birth. The percentage of cycles resulting in live births will give a more accurate answer to the question, "If I have an ART procedure, what is my chance that I will have a baby?"

It is important to note that ART success rates vary in the context of patient and treatment characteristics. These characteristics include age, infertility diagnosis, number of embryos transferred, type of ART procedure, use of techniques such as ICSI, and history of previous births, miscarriages, and ART cycles.

11. If a patient has had more than one ART treatment cycle, how is the success rate calculated? Alternatively, how many cycles does a patient usually go through before getting pregnant?

As required by law, this report presents ART success rates in terms of how many cycles were started each year. Because clinics report information based on outcomes for each cycle started, success rates on a "per patient" basis, or the number of cycles that an average patient may undergo before achieving success are not presented in this report. While it is possible to achieve success with one ART cycle, success rates vary in the context of patient and treatment characteristics. Consumers should consult with their physician to understand their specific medical situation and their chances of using ART.

12. What quality control steps are used to ensure data accuracy?

To have their success rates published in this annual report, clinics have to submit their data in time for analysis and the clinics' medical directors have to verify by signature that the tabulated success rates are accurate. Then, Westat conducts an in-house review and contacts the clinics if corrections are necessary. After the data have been verified, a quality control process called validation begins. This year, 35 of the 451 reporting clinics were selected after taking into consideration some cycle and clinic characteristics and whether the clinic had been selected before. (See Appendix A: Technical Notes on page 509 for a more detailed presentation of sampling strategy.) Members of the Westat Validation

Team visit these clinics and review medical record data for a sample of the clinic's ART cycles. For each cycle, the validation team abstracts information from the patient's medical record. The abstracted information is then reviewed onsite and compared with the data submitted for the report. The data validation process does not include any assessment of clinical practice or overall record keeping. Validation primarily helps ensure that clinics submit accurate data. It also serves to identify any systematic problems that could cause data collection to be inconsistent or incomplete. Findings and discrepancy rates from the 2011 validation visits will be available on the CDC Web site later this year at <http://www.cdc.gov/art/ARTReports.htm>.

13. How does CDC use the variables/data collected but not reported in the annual *Assisted Reproductive Technology Fertility Clinic Success Rates Report* and *National Summary Report*?

CDC uses the data collected and not reported in the annual ART reports to evaluate emerging ART research questions and to monitor safety and efficacy issues related to ART treatment for improving maternal and child outcomes. Other data may not be released in order to protect the ART patient's confidentiality. A list of ART publications is available at <http://www.cdc.gov/art/pubs.htm>.

14. How does CDC ensure the confidentiality of the ART data it collects?

CDC has an Assurance of Confidentiality for the ART database. An Assurance of Confidentiality is a formal confidentiality protection authorized under Section 308(d) of the Public Health Service Act (42 U.S.C. 242[m]). An assurance is used for projects conducted by CDC staff or contractors involving the collection or maintenance of sensitive identifiable or potentially identifiable information. The assurance allows CDC programs to assure that individuals and institutions involved in research or nonresearch projects protect the confidentiality of the data collected. Under Public Health Service Act Section 308(d), no identifiable information may be used for any purpose other than the purpose for which it was supplied unless such institution or individual has consented to that disclosure. CDC's current Assurance of Confidentiality for this project is ongoing.

15. Why doesn't the report contain specific medical information about ART?

This report describes a woman's average chances of success per ART cycle. Although the report provides some information about factors such as age and infertility diagnosis, consumers face many unique medical situations. This population-based registry of ART procedures cannot capture detailed information about specific medical conditions associated with infertility. Consumers should consult with their physician to understand their specific medical situation and their chances of success using ART.

16. Why are statistics in the *Fertility Clinic Tables* published by CDC different from statistics reported by SART's *IVF Success Rate Reports*?

During 1996–2011, the percentage of ART clinics reporting data to CDC with a SART membership ranged from approximately 84% to 95%. Annual summary statistics of ART treatments performed in each of these clinics are available online at <http://www.sart.org>. Although many of the same table items are used in both the CDC's *Fertility Clinic Tables* and SART's *IVF Success Rate Reports*, discrepancies in tabulated statistics between the SART and CDC tables may be due to (1) the inclusion

in the CDC Fertility Clinic Reports of ART treatments performed at non-SART member clinics; (2) differences in the data submission deadlines between SART and CDC, which may result in ART clinics being excluded from CDC's annual Fertility Clinic Reports; and (3) differences in data processing procedures and statistical methods used to generate statistics.

17. Does CDC have any information on the women who donate eggs?

CDC only collects information on the age of egg donors, but does not present it in the individual clinic tables for this report. In 2011, the average age of egg donors was approximately 28 years. Success rates for cycles using donor eggs or using embryos derived from donor eggs is related to the age of the woman who produced the eggs. Thus, the percentage of transfers that resulted in live births for cycles using fresh embryos from donor eggs remained consistently high—above 50% among most patients of different ages.

18. Are there any medical guidelines for ART performed in the United States?

The American Society for Reproductive Medicine (ASRM) and the Society of Assisted Reproductive Technology (SART) issue guidelines dealing with specific ART practice issues, such as the number of embryos to be transferred in an ART procedure. Further information can be obtained from ASRM or SART (both at telephone 205-978-5000 or Web sites <http://www.asrm.org> and <http://www.sart.org>).

19. Where can I get additional information on U.S. fertility clinics?

For further information on specific clinics, contact the clinic directly (see Appendix C for current contact information). In addition, SART can provide general information on its member clinics (telephone 205-978-5000, extension 109).

20. What's new in the 2011 report?

CDC is constantly striving to present the most accurate and relevant ART clinic success rates to help potential ART users make decisions. Changes to the clinic table and National Summary table format have been made to provide a more comprehensive and user-friendly presentation of clinic and national success rates data. Highlights of modifications designed to enhance clarity, readability, and improve the presentation of data include the following:

2011 ART Cycle Profile Section

- GIFT/ZIFT percentages are no longer shown.
- Total patient diagnosis percentages may be greater than 100% because more than one diagnosis could be reported for each cycle.
- Elective single embryo transfer (eSET) information is now reported in the 2011 ART Success Rates section.

2011 ART Success Rates Section

- Addition of total number of ART cycles performed (excluding banking cycles) for each clinic.
- Addition of footnote providing the total number of oocyte/embryo banking cycles for each clinic.
- Addition of success rates for women older than age 44 (>44).
- Addition of percentages of eSET by age of woman for fresh nondonor cycles.
- Rearrangement and grouping of success rates according to the order and occurrence of ART events (e.g., per cycle, transfer, or pregnancy).
- Elimination of confidence intervals and inclusion of denominators used to calculate success rates for each indicator (e.g., number of cycles, transfers, and pregnancies).
- Addition of select outcomes per pregnancy for fresh nondonor cycles and expanded outcomes of interest for frozen nondonor cycles and donor cycles.
- Addition of highlighted rates for the most favorable measure of ART success—singleton live births—for each cycle type (e.g., fresh, frozen, donor).

Lastly, all known nonreporting clinics are now included in alphabetical order in the Fertility Clinic Tables section of this report, although no data are presented for these clinics.

2011 Fertility Clinic Tables



INTRODUCTION TO FERTILITY CLINIC TABLES

The first table in this section is the 2011 National Summary of combined data from all clinics. Individual clinic tables follow, with each clinic's data presented in a one-page table that includes the types of assisted reproductive technology (ART) used, patient diagnoses, success rates, and individual clinic characteristics. Clinics reporting their data to the Centers for Disease Control and Prevention (CDC) are listed in alphabetical order by state, city, and clinic name. Each known nonreporting clinic is also included in alphabetical order, although no data are presented for these clinics.

Many people considering ART will want to use this report to find the “best” clinic. However, comparisons between clinics must be made with caution. Many factors contribute to the success of an ART procedure. Some factors are related to the training and experience of the ART clinic and laboratory professionals and the quality of services they provide. Other factors are related to the patients themselves, such as their age, quality of their eggs and sperm, cause of their infertility, genetic factors, and diagnosis. Some clinics may be more willing than others to accept patients with low chances of success or may specialize in ART treatments that attract particular types of patients.

We encourage consumers considering ART to contact clinics to discuss their specific medical situations and their potential for success using ART. Because clinics did not have the opportunity to provide narratives to explain their data in this report, such conversations could provide additional information to help consumers decide whether to use ART.

Although ART offers important options for the treatment of infertility, the decision to use ART involves many factors in addition to success rates. Therefore, consumers should carefully examine all related financial, psychological, and medical issues before beginning treatment. They also will want to consider the location of the clinic, the counseling and support services available, and the rapport that staff members have with their patients.

Important Factors to Consider When Using These Tables to Assess a Clinic

- ***These statistics are for 2011.*** Data for cycles started in 2011 could not be published until 2013 because the final outcomes of pregnancies conceived in December 2011 were not known until October 2012. Additional time was then required to collect and analyze the data and prepare the report. Many factors that contribute to a clinic's success rate may have changed in the 2 years since these cycles were performed. Personnel may be different. Equipment and training may or may not have been updated. As a result, success rates for 2011 may not necessarily represent current rates.

- **No reported success rate is absolute.** A clinic's success rates may vary from year to year even if all determining factors remain the same. The more cycles that a clinic carries out, the less the rate is likely to vary. Conversely, clinics that perform fewer cycles are likely to have more variability in success rates from year to year. As an extreme example, if a clinic reports only one ART cycle in a given category, as is sometimes the case in the data presented here, the clinic's success rate in that category would be either 0% or 100%. Because success rates may be misleading if they are based on a small number, the rates are shown as fractions rather than percentages when fewer than 20 cycles or outcomes (pregnancies, transfers, births) are reported in a given category.
- **Some clinics see more than the average number of patients with difficult infertility problems.** Some clinics are willing to offer ART to most potential patients, even those who have a low probability of success. Others discourage such patients or encourage them to use donor eggs, a practice that results in higher success rates among older women. Clinics that accept a higher percentage of women who previously have had multiple unsuccessful ART cycles will generally have lower success rates. In contrast, clinics that offer ART procedures to women who might have become pregnant with less technologically advanced treatment will generally have higher success rates.
- **The percentage of cycles that are canceled varies.** Percentages of canceled cycles using fresh nondonor eggs or embryos vary among clinics from less than 1% to, in a few cases, more than 25%. A high percentage of cancellations tends to lower the percentage of cycles resulting in live births but may increase the percentage of embryo transfers resulting in live births.
- **Percentages of unstimulated (or "natural") cycles are included with those for stimulated cycles.** In an unstimulated cycle, the woman ovulates naturally rather than through the daily injections used in stimulated cycles. Unstimulated cycles are less expensive because they require no daily injections and fewer ultrasounds and blood tests. However, women who use natural or mild stimulation produce only one or two follicles, thus reducing the potential number of embryos for transfer. As a result, clinics that perform a relatively high percentage of unstimulated cycles may have lower success rates. Nationally, 1% of ART cycles using fresh nondonor eggs or embryos in 2011 were unstimulated.
- **Success rates are calculated per cycle rather than per patient.** Success rates shown in this report are presented in terms of cycles, as required by law, rather than in terms of patients. As a result, patients who had more than one ART cycle in 2011 are represented in multiple cycles that are not linked. In addition, for patients who undergo both fresh and frozen cycles, success rates are calculated separately for each cycle. Clinics that have a very high percentage of cycles resulting in live births with frozen embryos would have higher ART success rates if these births were included as successes from the original stimulated cycle. Consumers should look at both rates (for cycles using fresh embryos and for those using frozen embryos) when assessing a clinic's success rates.

- ***The number of embryos transferred varies from clinic to clinic.*** In 2011, the average number of embryos that a clinic transferred to women younger than age 35 ranged from 1.0 to 3.5 for fresh nondonor cycles. The American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) discourage the transfer of a large number of embryos because of the increased likelihood of multiple-fetus pregnancies. Multiple-fetus pregnancies, in turn, increase the probability of premature births and related health problems.

An explanation of how to read a fertility clinic table begins on page 17.

SAMPLE CLINIC TABLE

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE

1 Type of ART and Procedural Factors ^a				2 Patient Diagnosis ^b			
IVF	99%	With ICSI	66%	Tubal factor	13%	Uterine factor	1%
Unstimulated	<1%	Used PGD	5%	Ovulatory dysfunction	6%	Male factor	19%
Used gestational carrier	<1%			Diminished ovarian reserve	9%	Other factor	7%
				Endometriosis	6%	Unknown factor	10%
				Multiple Factors: Female factors only 13% Female & male factors 28%			

5 2011 ART SUCCESS RATES ^{c,d}			3 Number of cycles in table: ^e 124			4 Data verified by Andrew B. Test, MD		
---	--	--	---	--	--	---------------------------------------	--	--

7	Type of Cycle	6 Age of Woman					
		<35	35–37	38–40	41–42	43–44	>44
7 Fresh Embryos from Nondonor Eggs							
	Number of cycles	115	106	68	19	12	5
	Percentage of cancellations	12.2	6.6	13.2	3 / 19	2 / 12	2 / 5
	Average number of embryos transferred	2.0	2.5	2.8	2.9	2.7	2.0
	Percentage of embryos transferred resulting in implantation	32.5	24.5	16.6	11.4	4.6	1 / 7
	Percentage of elective single embryo transfer (eSET)	5.5	1.2	3.8	1 / 15	0 / 8	0 / 3
7A Outcomes per Cycle							
	Percentage of cycles resulting in singleton live births	28.6	21.7	14.7	1 / 19	0 / 12	1 / 5
	Percentage of cycles resulting in triplets or more live births	1.7	1.8	2.9	1 / 19	0 / 12	0 / 5
	Percentage of cycles resulting in live births	37.4	31.1	20.6	2 / 19	1 / 12	1 / 5
	Percentage of cycles resulting in pregnancy	45.2	37.7	23.5	5 / 19	1 / 12	1 / 5
7B Outcomes per Transfer							
	Number of transfers	90	85	52	15	8	3
	Percentage of transfers resulting in singleton live births	36.7	27.1	19.2	1 / 15	0 / 8	1 / 3
	Percentage of transfers resulting in triplets or more live births	2.2	2.4	3.8	1 / 15	0 / 8	0 / 3
	Percentage of transfers resulting in live births	47.7	38.8	26.9	2 / 15	1 / 8	1 / 3
	Percentage of transfers resulting in pregnancy	57.8	47.0	30.8	5 / 15	1 / 8	1 / 3
7C Outcomes per Pregnancy							
	Number of pregnancies	52	40	16	5	1	1
	Percentage of pregnancies resulting in singleton live births	63.5	57.5	10 / 16	1 / 5	0 / 1	1 / 1
	Percentage of pregnancies resulting in triplets or more live births	3.8	5.0	2 / 16	1 / 5	0 / 1	0 / 1
	Percentage of pregnancies resulting in live births	82.7	82.5	14 / 16	2 / 5	1 / 1	1 / 1
8 Frozen Embryos from Nondonor Eggs							
	Number of cycles	75	30	25	20	15	10
	Number of transfers	62	25	20	14	8	5
	Average number of embryos transferred	2.1	2.0	2.7	2.0	2.7	2.0
	Percentage of embryos transferred resulting in implantation	31.2	30.0	20.4	14.3	9.3	2 / 10
	Percentage of transfers resulting in singleton live births	21.0	24.0	10.0	1 / 14	1 / 8	0 / 5
	Percentage of transfers resulting in triplets or more live births	1.7	4.0	5.0	0 / 14	0 / 8	0 / 5
	Percentage of transfers resulting in live births	27.4	36.0	20.0	2 / 14	1 / 8	1 / 5
	Percentage of transfers resulting in pregnancy	61.3	48.0	45.0	3 / 14	2 / 8	1 / 5

9	Donor Eggs	All Ages Combined ^f	
		Fresh Embryos	Frozen Embryos
	Number of cycles	60	19
	Number of transfers	49	14
	Average number of embryos transferred	2.1	2.4
	Percentage of embryos transferred resulting in implantation	46.7	26.9
	Percentage of transfers resulting in singleton live births	45.0	3 / 14
	Percentage of transfers resulting in live births	51.0	7 / 14
	Percentage of transfers resulting in pregnancy	71.4	9 / 14

CURRENT CLINIC SERVICES AND PROFILE

10 Current Name: Sample Clinic					
Donor egg?	Yes	Gestational carriers?	Yes	SART member?	Yes
Donor embryo?	Yes	Embryo cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			(See Appendix C for details.)	

^a Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.
^b Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.
^c A multiple-infant birth is counted as one live birth if at least one infant is live born.
^d When denominator is <20, rates are shown as fractions. Calculating percentages from these fractions may be misleading.
^e Number excludes 0 oocyte/embryo banking cycle(s). (If 0, no banking cycles were reported.)
^f All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.

How to Read a Fertility Clinic Table

This section is provided to help consumers understand the information presented in the fertility clinic tables. The number before each heading refers to the number of the corresponding section in the sample clinic table on the opposite page. Technical terms are defined in the Glossary of Terms (see Appendix B on pages 513–515).

1. Type of ART and procedural factors

This section gives the percentage of in vitro fertilization (IVF) cycles performed using fresh nondonor embryos. It also lists the percentage of ART cycles using fresh nondonor eggs or embryos that were unstimulated, that used a gestational carrier, that involved intracytoplasmic sperm injection (ICSI), and that used preimplantation genetic diagnosis (PGD).

2. Patient diagnosis

This section gives the percentage of ART cycles for which patients had a particular diagnosis out of the total number of cycles performed at the clinic. Consumers may want to know what percentage of cycles are performed for a clinic's patients with the same diagnosis as they have. In addition, patients' diagnoses may affect a clinic's success rates. However, the use of these diagnostic categories may vary somewhat from clinic to clinic, and total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.

3. Number of cycles in table

This is the total number of ART cycles started at the clinic in 2011 that are used to calculate success rates within the three categories of cycles included in Sections 7–9. This number excludes ART cycles started with the intention of cryopreserving (freezing) all resulting oocytes/embryos for potential future use and any cycles started in which a new procedure was being evaluated (a small number nationwide). These two types of cycles are not used to calculate clinic success rates presented in the table.

4. Verification

To have success rates published in the annual report, a clinic's medical director must verify the accuracy of the data reported to CDC. The name of the medical director who verified the clinic's data is shown.

5. Success rates by type of cycle

Success rates are given for the three categories of ART cycles included in Sections 7–9: cycles using fresh embryos from nondonor eggs, cycles using frozen embryos from nondonor eggs, and cycles using donor eggs. The success rates shown are calculated on the basis of data from all ART cycle procedures (IVF, gamete intrafallopian transfer or GIFT, and zygote intrafallopian transfer or ZIFT).

Success rates for the birth of a single live infant (a singleton live birth) are emphasized in the table because they are an important measure of success. Multiple-infant births are associated with increased risk of adverse outcomes for mothers and infants, including higher rates of caesarean section, prematurity, low birth weight, and infant disability or death.

Clinic table success rates indicate the average chance of success for cycles started at the clinic in 2011. Success rates are calculated by ART cycle stage (start, transfer, pregnancy) and by age group or for all ages combined. For example, if a clinic started 50 cycles in 2011, and these resulted in 15 live births, the average success rate for cycles started at that clinic would be

$$15 \text{ (births)} \div 50 \text{ (cycles)} = 0.3 \text{ or } 30\%$$

Thus, the success rate at that clinic in 2011 was 30%, meaning that 30% of cycles started that year resulted in a live birth.

Success rate calculations may be misleading if they are based on a small number. Therefore, when fewer than 20 cycles or outcomes (pregnancies, transfers) are reported in a given category, the rates are shown as fractions rather than percentages. For example, suppose that the sample clinic performed only 19 fresh embryo cycles using nondonor eggs among women aged 41–42 years. Of these 19 cycles, 2—or about 10%—resulted in a live birth. However, because of the small number of cycles, 10% is not a statistically reliable success rate, so the success rate is presented as 2/19, meaning 2 out of 19 cycles started resulted in a live birth.

6. Age of woman

Because a woman's fertility declines with age, clinics report lower success rates for older women attempting to become pregnant with their own eggs. For this reason, rates for women using nondonor eggs or embryos are reported separately for women younger than age 35, for women aged 35–37, aged 38–40, aged 41–42, aged 43–44, and for woman older than age 44. The sample clinic table illustrates the decline in ART success rates among older women. For example, for cycles that used fresh embryos from nondonor eggs, the percentage of cycles resulting in live births among women younger than age 35 was 37.4%, whereas the percentage of cycles resulting in live births among women aged 38–40 was 20.6%.

7. Cycles using fresh embryos from nondonor eggs

This section includes success rates for all ART cycles started with the intent to use fresh embryos from a woman's own eggs.

- **Number of cycles**

This represents the number of ART cycles by age of woman.

- **Percentage of cancellations**

(Number of cycles canceled divided by the total number of cycles, expressed as a percentage of cycles.)

This refers to the cycles that were stopped before an egg retrieval was attempted. A cycle may be canceled if a woman's ovaries do not respond to fertility medications and thus do not produce a sufficient number of follicles. Cycles also may be canceled because of illness or other medical or personal reasons.

- **Average number of embryos transferred**

(Average number of embryos per transfer procedure in which one or more embryos were transferred.)

The average number of embryos transferred varies from clinic to clinic. ASRM and SART have practice guidelines that address this issue. Further information can be obtained from ASRM or SART (both at telephone 205-978-5000 or Web sites <http://www.asrm.org> and <http://www.sart.org>).

- **Percentage of embryos transferred resulting in implantation**

(The larger of either the maximum number of fetal hearts or maximum number of infants born [live births + stillbirths] divided by the number of embryos transferred, expressed as a percentage of embryos transferred.)

This represents the cycles resulting in an intrauterine clinical pregnancy out of the total number of embryos transferred, in which one or more embryos were transferred. Not all fetal hearts can be detected by ultrasound. For this reason, a positive intrauterine clinical pregnancy is defined as the larger of either the maximum number of fetal hearts detected by ultrasound or maximum number of infants born, including live births and stillbirths.

- **Percentage of elective single embryo transfer (eSET)**

(The number of cycles in which 1 embryo was transferred and >0 embryos were cryopreserved, divided by the number of transfer procedures in which either 1 embryo was transferred and >0 embryos were cryopreserved or >1 embryos were transferred, expressed as a percentage of these transfer procedures.)

This represents the cycles in which one embryo is selected to be transferred from a larger number of available embryos, usually for the purpose of reducing the chance of having a multiple birth. For these cycles, one or more of the extra embryos are cryopreserved during the current cycle for future use.

7A. Outcomes per cycle

In this section, success rates using fresh embryos from nondonor eggs are calculated as a percentage of the fresh nondonor ART cycles started. The number of cycles that a clinic starts is not the same as the number of patients treated because some patients start more than one cycle in a year.

- **Percentage of cycles resulting in singleton live births**

(Number of singleton live births divided by number of cycles, expressed as a percentage of cycles.)

This represents the cycles that resulted in the birth of a single live infant out of all cycles started.

- **Percentage of cycles resulting in triplets or more live births**

(Number of triplet or more live births divided by number of cycles, expressed as a percentage of cycles.)

This represents the cycles that resulted in a triplet or more live birth out of all cycles started. A multiple-infant birth with one or more infants born live is counted as one live birth.

- **Percentage of cycles resulting in live births**

(Number of live births divided by number of cycles, expressed as a percentage of cycles.)

This represents the cycles that resulted in a live birth out of all cycles started. A cycle resulting in live birth may include one or more infants born alive; that is, a multiple-infant birth (e.g., twins, triplets) with at least one live-born infant is counted as one live birth.

- **Percentage of cycles resulting in pregnancy**

(Number of pregnancies divided by number of cycles, expressed as a percentage of cycles.)

This represents the cycles that resulted in a pregnancy out of all cycles started. Because some pregnancies end in a miscarriage, induced abortion, or stillbirth, the percentage of cycles resulting in pregnancies is usually higher than the percentage of cycles resulting in live births.

7B. Outcomes per transfer

In this section, success rates using fresh embryos from nondonor eggs are calculated as a percentage of fresh nondonor ART cycles in which an embryo transfer procedure was attempted, even if no embryos were successfully transferred. A clinic may begin cycles that do not proceed to transfer because not every cycle started results in successful egg retrieval, fertilization, and embryo transfer. For this reason, percentages of transfers resulting in pregnancies and live births generally are higher than the percentage for cycles started.

- **Number of transfers**

This represents the number of transfers by age of woman.

- **Percentage of transfers resulting in singleton live births**

(Number of singleton live births divided by number of transfers, expressed as a percentage of transfers.)

This represents the transfer procedures that resulted in the birth of a single live infant out of all cycles in which a transfer was attempted.

- **Percentage of transfers resulting in triplets or more live births**

(Number of triplet or more live births divided by number of transfers, expressed as a percentage of transfers.)

This represents the transfer procedures that resulted in a triplet or more live birth out of all cycles in which a transfer was attempted. A multiple-infant birth with one or more infants born live is counted as one live birth. Multiple-fetus pregnancies and multiple-infant births are associated with increased risk of adverse outcomes for mothers and infants, including higher rates of caesarean section, prematurity, low birth weight, and infant disability or death.

- **Percentage of transfers resulting in live births**

(Number of live births divided by number of transfers, expressed as a percentage of transfers.)

This represents the transfer procedures that resulted in a live birth out of all cycles in which a transfer was attempted. A transfer resulting in live birth may include one or more infants born alive; that is, a multiple-infant birth (e.g., twins, triplets) with at least one live-born infant is counted as one live birth.

- **Percentage of transfers resulting in pregnancy**

(Number of pregnancies divided by number of transfers, expressed as a percentage of transfers.)

This represents the transfer procedures that resulted in a pregnancy out of all cycles in which a transfer was attempted. Because some pregnancies end in a miscarriage, induced abortion, or stillbirth, the percentage of transfers resulting in pregnancies is usually higher than the percentage of transfers resulting in live births.

7C. Outcomes per pregnancy

In this section, success rates using fresh embryos from nondonor eggs are calculated as a percentage of fresh nondonor ART cycles resulting in pregnancy. A pregnancy with more than one fetus is counted as one pregnancy. Because not every cycle started results in successful egg retrieval, fertilization, transfer, and pregnancy, the percentage of pregnancies resulting in live births generally is higher than percentages for cycles started or transfers attempted.

- **Number of pregnancies**

This represents the number of pregnancies by age of woman.

- **Percentage of pregnancies resulting in singleton live births**

(Number of singleton live births divided by number of pregnancies, expressed as a percentage of pregnancies.)

This represents the pregnancies that resulted in the birth of a single live infant out of all cycles resulting in a pregnancy. It includes multiple-fetus pregnancies that may have been reduced to a single-fetus pregnancy by the time of birth, either naturally (e.g., fetal death) or because a woman and her doctor decided to reduce the number of fetuses through a procedure called multifetal pregnancy reduction. (CDC does not collect information on multifetal pregnancy reductions.)

- **Percentage of pregnancies resulting in triplets or more live births**

(Number of triplet or more live births divided by number of pregnancies, expressed as a percentage of pregnancies.)

This represents the pregnancies that resulted in a triplet or more live birth out of all cycles resulting in a pregnancy. A multiple-infant birth with one or more infants born live is counted as one live birth. Multiple-fetus pregnancies and multiple-infant births are associated with increased risk of adverse outcomes for mothers and infants, including higher rates of caesarean section, prematurity, low birth weight, and infant disability or death.

- **Percentage of pregnancies resulting in live births**

(Number of live births divided by number of pregnancies, expressed as a percentage of pregnancies.)

This represents the pregnancies that resulted in a live birth out of all cycles resulting in a pregnancy. A pregnancy resulting in live birth may include one or more infants born alive; that is, a multiple-infant birth (e.g., twins, triplets) with at least one live-born infant is counted as one live birth.

8. Cycles using frozen embryos from nondonor eggs

Frozen (cryopreserved) embryo cycles are those in which previously frozen embryos are thawed and then transferred. Because frozen embryo cycles use embryos formed from a previous cycle, no stimulation or retrieval is involved in the current cycle. As a result, these cycles usually are less expensive and less invasive than cycles using fresh embryos. In addition, freezing some of the embryos from a retrieval procedure may increase a woman's overall chances of having a child from a single retrieval.

In this section, success rates for ART cycles using frozen embryos from nondonor eggs are calculated as a percentage of transfers. A clinic may begin cycles that do not proceed to transfer because not every cycle started results in the successful thaw of previously frozen embryos or proceeds to transfer. Thus, the number of transfers attempted is usually lower than the number of cycles started. See Sections 7 and 7B for the interpretation of success rates.

9. Cycles using donor eggs

Older women, women with premature ovarian failure (early menopause), women whose ovaries have been removed, and women with a genetic concern about using their own eggs may consider using eggs that are donated by a young, healthy woman. Embryos donated by patients who previously had ART also may be available. Many clinics provide services for donor egg and embryo cycles.

In this section, success rates are presented separately for ART cycles using fresh donor eggs or embryos and those using frozen donor embryos. For these cycle types, results from women in all age groups are reported together because previous data show that patient age does not affect success rates with donor eggs. Success rates using donor eggs or embryos are calculated as a percentage of transfers. See Sections 7 and 7B for the interpretation of success rates.

10. Current clinic services and profile

- **Current name.** This may reflect a clinic name change that occurred since 2011, whereas the clinic name at the top of the table was the name of the ART clinic as it existed in 2011. Some clinics not only have changed their names but have reorganized as well. Reorganization is defined as a change in ownership or affiliation or a change in at least two of the three key staff positions (practice director, medical director, or laboratory director). In such cases, no current name is listed, but a statement that the clinic has undergone reorganization since 2011 is included, and no current clinic services or profile are listed.
- **Donor egg.** Some clinics have programs for ART using donor eggs. Donor eggs are eggs that have been retrieved from one woman (the donor) and then transferred to another woman (the recipient). Policies regarding sharing of donor eggs vary from clinic to clinic.

- **Donor embryo.** These are embryos that were donated by other patients who previously underwent ART treatment and had extra embryos available.
- **Single women.** Clinics have varying policies regarding ART services for single (unmarried) women.
- **Gestational carriers.** A gestational carrier is a woman who carries a child for others; sometimes such women are referred to as gestational surrogates. Policies regarding ART services using gestational carriers vary from clinic to clinic. Some states do not permit clinics to offer this service.
- **Embryo cryopreservation.** This item refers to whether the clinic has a program for freezing extra embryos that may be available from a patient's ART cycle.
- **SART member.** In 2011, 378 of the 451 reporting clinics were SART members.
- **Verified lab accreditation.** If "Yes" appears next to this item, the ART clinic uses an embryo laboratory accredited by one or more of the following organizations:
 - College of American Pathologists/ASRM, Reproductive Laboratory Accreditation Program (CAP/ASRM).
 - The Joint Commission.
 - New York State Tissue Bank Program (NYSTB).

If "Pending" appears here, it means that the clinic has submitted an application for accreditation to one of the above organizations and has provided proof of such application to CDC. "No" indicates that the embryo laboratory has not been accredited by any of these three organizations.

CDC provides this information as a public service. Please note that CDC does not oversee any of these accreditation programs. They are all nonfederal programs. To become certified, laboratories must have in place systems and processes that comply with the accrediting organization's standards. Depending on the organization, standards may include those for personnel, quality control and quality assurance, specimen tracking, results reporting, and the performance of technical procedures. Compliance with these standards is confirmed by documentation provided by the laboratory and by on-site inspections. For further information, consumers may contact the following accrediting organizations directly:

- CAP/ASRM: For a list of accredited laboratories, call 800-323-4040 and follow the prompts for Laboratory Accreditation.
- The Joint Commission: Call 630-792-5800 to inquire about the status of individual laboratories.
- NYSTB: Call 518-485-5341 to find out which laboratories are certified under the tissue bank regulations.

Further information on laboratory accreditation for specific clinics is provided in Appendix C.

2011 NATIONAL SUMMARY

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about how to interpret the statistics in this table, see pages 13–23.

2011 ART CYCLE PROFILE			
Type of ART and Procedural Factors ^a		Patient Diagnosis ^b	
IVF	>99%	With ICSI	67%
Unstimulated	1%	Used PGD	5%
Used gestational carrier	<1%		
		Tubal factor	14%
		Ovulatory dysfunction	14%
		Diminished ovarian reserve	30%
		Endometriosis	10%
		Uterine factor	5%
		Male factor	34%
		Other factor	15%
		Unknown factor	12%
		Multiple Factors:	
		Female factors only	11%
		Female & male factors	18%

2011 ART SUCCESS RATES ^c		Number of cycles in table: ^d 151,923					
Type of Cycle		Age of Woman					
		<35	35–37	38–40	41–42	43–44	>44
Fresh Embryos from Nondonor Eggs							
Number of cycles		42,059	20,963	21,128	10,733	4,744	1,586
Percentage of cancellations		6.4	9.4	12.5	16.1	18.2	26.8
Average number of embryos transferred		2.0	2.2	2.5	3.0	3.1	2.6
Percentage of embryos transferred resulting in implantation		35.6	27.3	17.3	9.4	4.5	1.9
Percentage of elective single embryo transfer (eSET)		12.2	7.0	2.2	0.7	0.4	1.2
Outcomes per Cycle							
Percentage of cycles resulting in singleton live births		27.2	22.9	16.7	10.2	4.7	1.1
Percentage of cycles resulting in triplets or more live births		0.5	0.4	0.3	0.1	0.0	0.0
Percentage of cycles resulting in live births		40.0	31.9	21.5	12.1	5.3	1.1
Percentage of cycles resulting in pregnancy		46.1	38.5	29.2	19.4	10.7	4.1
Outcomes per Transfer							
Number of transfers		36,493	17,410	16,625	7,892	3,277	868
Percentage of transfers resulting in singleton live births		31.3	27.6	21.2	13.9	6.8	2.0
Percentage of transfers resulting in triplets or more live births		0.6	0.5	0.4	0.1	0.0	0.0
Percentage of transfers resulting in live births		46.0	38.4	27.3	16.5	7.6	2.1
Percentage of transfers resulting in pregnancy		53.1	46.3	37.1	26.4	15.5	7.5
Outcomes per Pregnancy							
Number of pregnancies		19,379	8,065	6,166	2,083	508	65
Percentage of pregnancies resulting in singleton live births		59.0	59.5	57.3	52.6	44.1	26.2
Percentage of pregnancies resulting in triplets or more live births		1.1	1.1	1.0	0.4	0.0	0.0
Percentage of pregnancies resulting in live births		86.7	82.9	73.7	62.4	49.2	27.7
Frozen Embryos from Nondonor Eggs							
Number of cycles		15,226	7,599	5,692	2,104	886	673
Number of transfers		14,271	7,051	5,239	1,923	787	609
Average number of embryos transferred		1.9	1.9	1.9	2.0	2.2	1.9
Percentage of embryos transferred resulting in implantation		30.8	27.9	23.1	18.3	12.5	12.0
Percentage of transfers resulting in singleton live births		29.1	28.2	24.1	20.2	14.7	13.0
Percentage of transfers resulting in triplets or more live births		0.4	0.2	0.3	0.2	0.1	0.2
Percentage of transfers resulting in live births		39.0	35.5	29.7	24.0	17.0	14.8
Percentage of transfers resulting in pregnancy		48.6	45.7	40.5	36.7	26.9	21.3
All Ages Combined^e							
Donor Eggs		Fresh Embryos			Frozen Embryos		
Number of cycles		10,797			7,733		
Number of transfers		9,767			7,143		
Average number of embryos transferred		1.9			1.9		
Percentage of embryos transferred resulting in implantation		45.9			27.7		
Percentage of transfers resulting in singleton live births		35.1			27.2		
Percentage of transfers resulting in live births		54.8			35.7		
Percentage of transfers resulting in pregnancy		64.7			45.5		

CURRENT CLINIC SERVICES AND PROFILE			
Percentage of clinics that offer the following services:		Clinic profile:	
Donor egg	93%	Gestational carriers	86%
Donor embryo	71%	Embryo cryopreservation	100%
Single women	95%	SART member	84%
		Verified lab accreditation	
		Yes	93%
		No	6%
		Pending	1%

^a Reflects features of fresh nondonor cycles. If IVF is <100%, the remaining cycles are GIFT, ZIFT or a combination of these procedures with IVF.

^b Total patient diagnosis percentages may be greater than 100% because more than one diagnosis can be reported for each cycle.

^c A multiple-infant birth is counted as one live birth if at least one infant is live born.

^d Number excludes 11,116 oocyte/embryo banking cycle(s) and 6 cycles in which new procedures were evaluated.

^e All ages are reported together because previous data show that patient age does not materially affect success with donor eggs.